STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085053	A. BUILDING _____ B. WING _____	10/26/2009

LTC Residents Protection
NOV 30 2009
Director's Office

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADBURY AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

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F 000	INITIAL COMMENTS An unannounced QIS survey was conducted at the facility from October 19, 2009 through October 26, 2009. The deficiencies contained in this survey are based on observations, interviews and review of residents' clinical records and review of other facility documentation as indicated. The survey sample included thirty (30) admission and thirty two (32) census residents in Stage I. The Stage II sample included twenty-three (23) residents.	F 000	Disclosure Statement: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of Federal and State law require it.	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156	1. Medicare benefits have been discontinued for RSS2 and RSS5. RSS2 has been discharged from the unit. RSS5 has been discharged from rehab and no longer has a need for skilled services. Both residents were notified of termination of benefits but lack documentation reflecting notification. We cannot go back and add documentation to the chart. 2. All residents that receive Medicare benefits are at risk of not having documentation informing resident of termination of benefits. A chart audit was completed by the admission coordinator on all discharges from Medicare benefits since survey ended on October 26, 2009. Attachment #1A and #1B. All charts had proper documentation to reflect that residents were notified of Medicare benefits being terminated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nelson D'Amico, LNHA	PRESIDENT & CEO	11/27/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 156	Continued From page 1 (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	3. Weekly utilization meetings are held with the MDS Coordinator, the Rehab Director, Social Worker, Admission Coordinator and the Director of Health Services. When the committee identifies a date that Medicare benefits will need to be terminated, the MDS coordinator initiates a termination memo to the appropriate disciplines. Attachment #2. Once the termination memo is initiated, it is reflected on the utilization review form under the labeled "term" column. Attachment #3. The Admission Coordinator initiates the notice of Medicare non-provider non-coverage form within 48 hours prior to being discharged from services. Attachment #4A and #4B. Once initiated, the Admission Coordinator will sign off on the utilization review form under the column labeled NEMB (non-eligible Medicare beneficiary) for the committee to review. Attachment 3. A copy of the notice of non-coverage form will be kept in the resident's chart. 4. On a monthly basis, the Admission Coordinator will audit all resident charts that have had Medicare benefits terminated to ensure compliance with notification being documented. This audit will be compiled into a report and reported quarterly at QI by the Admission Coordinator. Attachment #5.	11/16/09

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and record review of the liability notices, it was determined that the facility failed to provide notice of termination of benefits for two (#RSS2 and #RSS5) out of six residents reviewed. Findings include: 1. There was no Notice of Medicare Provider Non-coverage letter provided for resident #RSS2. 2. There was no Notice of Medicare Provider	F 156		

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F 156	Continued From page 3 Non-coverage letter provided for resident #RSS5.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to consult with	F 157	1. R57 was receiving a Fentanyl patch of 50mcq topically. Attachment #6A & #6B. On 10/21/09 at 10:30 p.m. R57 was medicated with Tylenol for complaints of shoulder pain. Attachment #6C & 6D. There is no documentation that reflects a request for oxycodone on 10/21/09. Attachment #7. At 2:00 a.m. R57 requested Tylenol again and was medicated as requested. Attachment 6C. His Fentanyl patch was re-applied at that time as well. Attachment #8. On the morning of 10/22/09 R57 asked for oxycodone and the doctor was notified, 5mg of oxycodone was given. Attachment 6C. R57 has since been discharged from the facility. R5 was medicated on 10/17 at 8:50 p.m. with Tylenol for complaints of a headache and neck pain per pain flow sheet. Attachment #9A. Relief was noted as documented on same pain flow sheet. She had been previously medicated for a headache on 10/3/09. Attachment #9A. On 10/18, R5 was medicated at 6:30 a.m. with Tylenol for complaints of headache and neck pain. The pain flow sheet reflects pain was effectively relieved. Attachment #9A. R5 had no further complaints of pain until 10:00 p.m. on 10/18/09 at which time Percocet was given. Attachment #9A and #9B. R5 had pain relief and rested quietly for the night with no further complaints of pain. Attachment	

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F 157	Continued From page 4 the physician for a significant change of condition for 2 (R57 and R5) out of 23 residents in the sample. One resident (R57) had a new onset of pain that was not communicated to the physician for over 10 hours. Another resident (R5) had a new onset of a headache that lasted several days before the physician was consulted. Findings include: 1. Cross refer F309 example #2. Based on nurses notes and resident interview it was revealed that R57 had a new onset of rheumatoid pain on 10/21/09. The resident requested the use of oxycodone which was the treatment when he was at home that was effective. The facility failed to consult with the physician when there was a new onset of pain and the resident's request for treatment with oxycodone. 2. Cross refer F309 example #3. R5 had a past medical history that included a cerebral vascular accident (stroke). In an interview conducted on 10/19/09 with R5 and her daughter it was stated that R5 began to experience a headache located at the back of her head on a regular basis approximately 3 days prior to today. Additionally R5 stated that the prescribed Tylenol (APAP) administered for any of her headaches was effective for only an hour. Clinical record review revealed that headaches sustained by R5 from 10/17/09 through 10/21/09 were rated moderately severe and ranged between 6 and 8 on a scale from 1 to 10. Further clinical record review revealed the absence of any documented consultation with the physician about the new onset of headaches	F 157	#9A and #9B. On 10/19/09 resident was medicated at 6:30 a.m. for complaints of pain to head and neck area. Resident out to doctor appointment on 10/19/09 and refused offer of Tylenol prior to going to see doctor. Attachment #9C. Returned from doctor appointment with no new orders. Continued to request and received Tylenol for head and neck pain with effectiveness noted on 10/19 at 6:30 p.m., 10/20 at 8:00 a.m. Attachment #9A. On 10/21/09 assessment made by RN to identify neck pain location. Attachment 9C. Medicated with Percocet at 6:00 p.m. and 10:00 p.m. with relief documented on pain flow sheet. Attachment #9A. On 10/22/09 doctor made aware of neck pain and head pain. Received orders for flexeril for three days. Attachment #10. Resident had no further complaints of head and neck pain after 10/22/09. 2. All residents have the potential to be at risk of not having the physician consulted immediately when there is a potential need to initiate a new form of treatment. All nursing will be in serviced to notify the physician if there is a significant change in condition which may require treatment. 3. The facility pain management policy has been revised to include reassessment for pain within two hours of implementation of intervention. If intervention is ineffective, the health	12/11/09

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F 157	Continued From page 5 including the intensity and severity of headaches voiced by R5 from 10/17/09 through 10/21/09 or her response to the medication used for relief. A recorded nurse's note dated 10/22/09 at 2:30 PM stated "...MD is to make rounds...Message via MD book to assess/(evaluate R5)...". Another nurse's note documented 10/22/09 at 4:00 PM stated "MD aware of (Resident #5's) neck pain...". The facility failed to immediately consult with the physician regarding moderately severe headaches sustained from 10/17/09 through 10/21/09 by R5 who had a history of a stroke.	F 157	care provider is to be notified for further orders. Attachment #11A-#11G. Nursing and physicians will be in serviced on the revised pain policy. 4. The Admission Coordinator will review 5 resident records monthly to ensure pain management policy and procedure is being followed and residents' pain is controlled at their acceptable level. Results will be reported at quarterly QI. Attachment #12	12/11/09
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	1. R57, R75 and R72 have been discharged from the facility. We cannot go back to update care plans. R42 had a care plan initiated on 11/16/09 for the use of a psychoactive medication. Attachment #13. 2. All residents who have pain are at risk to not have a care plan that addresses the residents assessed pain. All residents who have psychoactive medications ordered are at risk of not having a care plan that reflects indication for use, monitoring side effects and non-pharmological interventions. The MDS Coordinator maintains a list of residents receiving psycoactive medications. Attachment #14. Charts were audited by MDS Coordinator to ensure care plans were accurate. Attachment #14.	11/16/09

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F 279	Continued From page 6 by: Based on record review and interview it was determined that for four (4) residents (R57, R75, R42, and R72) out of 23 sampled residents the facility failed to develop a comprehensive care plan for an identified resident care area. One resident (R57) did not have a care plan for the assessed pain. Three (R75, R42, and R72) residents did not have a care plan for use of a psychoactive medication. Findings include: 1. Cross refer F309, example #2. R57 was admitted to the facility with back and stomach pain and was on pain medication both on a routine and as needed bases. The resident developed increased stomach pain and a new onset of shoulder pain that required a change in treatment for pain. The resident's initial MDS dated 9/12/09 indicated moderate pain daily. The facility failed to develop a care plan that addressed the resident's assessed pain. 2. Cross refer F329, example #1. R75 was started on an antianxiety medication xanax as need on 8/15/09. The facility failed to establish a care plan for the use of a psychoactive medication including it's indication for use, monitoring needs, side effects and non-pharmalogical interventions personalized to meet the resident needs. 3. Cross refer F329, example #2. R42 was started on the antianxiety medication ativan on 9/24/09 to be used every 8 hours. On 9/29/09 the medication dose and frequency was	F 279	All charts were audited by ADOHS/designee 11/18/09 to identify pain medication orders and to ensure care plans accurately reflected assessed pain. Attachment # 15. All nursing admissions will have an alteration in comfort care plan initiated as part of the admission process. Attachment #11e. All nursing will be in serviced on initiating and updating care plans for pain and psychoactive medications. New admissions on psychoactive drugs will be reviewed by MDS Coordinator to ensure care plan is in place and accurate. 4. The MDS Coordinator reviews 5 charts per month to ensure residents on psychoactive medications have accurate care plans. Results are reported at quarterly QI - Attachment #16. The Admission Coordinator will review 5 charts per month to ensure pain care plans are accurate and in place. Results will be reported at quarterly QI. Attachment #12.	11/18/09 12/11/09

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F 279	Continued From page 7 decreased and an as needed dose was also added. The facility failed to establish a care plan for the use of a psychoactive medication including it's indication for use, monitoring needs, side effects and non-pharmalogical interventions personalized to meet the resident needs. 4. R72's admission MDS assessment dated 7/17/09 indicating no mood indicators. Subsequent MDS assessments dated 7/24/09 and 8/7/09 indicated the presence of mood indicators including sadness and crying up to five days per week. Review of nurse's note dated 7/19/09 timed 12:15 PM documented R72 "cried when out of bed to the wheelchair." R72 was ordered and started on Remeron (medication to treat depression) 7.5 mg. (milligram) by mouth at bedtime on 7/20/09. Record review lacked evidence of a care plan for R72's depressed mood and crying. . An interview with the Registered Nurse Assessment Coordinator, E13 on 10/23/09 at approximately 3 PM confirmed that the facility failed to develop a care plan for R72 pertaining to the depressed mood.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	1. R27 and R75 have been discharged. We cannot go back to update care plans for them. Resident #30 remains in the facility. The initial pain that she was care planned for on 12/30/08 has resolved. We cannot go back and add interventions that were used but not	

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F 280	Continued From page 8 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R27, R75,R30, and R5) residents of 23 residents in the sample the facility failed to update and revise care plans when approaches were changed or initiated. Findings include: 1. R27 had a care plan dated 6/1/09 for potential for skin breakdown that included the approaches pressure relief mattress and protective skin barrier. There was also a care plan dated 6/1/09 for left buttocks excoriation that included treatment as ordered and weekly skin assessments. The care plan was not updated for approaches beyond the initial care plan to reflect necessary preventive measures to prevent further skin breakdown of other high risk areas including off loading and protecting of the heels. 2. R75's records indicated a diagnosis of anxiety	F 280	documented on care plan. Currently resident #30 has a care plan that addresses resident's pain from arthritis. All non-pharmacological interventions are included in the care plan. Attachment #17. Resident #5 remains in the facility. The head and neck pain that resident experienced has resolved. We cannot go back to revise the care plan specific to the head and neck pain. The care plan currently reflects goals and interventions and addresses effectiveness of pain relief when having pain. Attachment #18. 2. All residents have the potential to not have care plans reflect approaches to prevent skin breakdown. All residents on psychoactive medications are at risk to not have care plans reflect non-pharmacological interventions. All residents with pain are at risk to not having a care plan that reflects non-pharmacological interventions and the effectiveness of interventions used to relieve pain. The ADOHS did a chart audit to review residents Braden scale. Based on Braden scale score, care plans were reviewed to ensure all preventative measures are in place to prevent skin breakdown. Attachment #19	11/20/09

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F 280	Continued From page 9 and physician's orders for the anxiety medication, xanax, to be used on an as needed basis. Review of the MAR indicted the resident used the xanax two times in August, seven times in September, and four times in October 2009. Interviews on 10/21/09 with the nurse E11 and aide E12 who care for R75 revealed that the resident becomes anxious about her oxygen tank being full and being left alone in bathroom. Staff indicated multiple approaches they use to calm her. Although the resident had a care plan for being anxious none of this information was addressed in the care plan. 3. Resident #30 was admitted to the facility on 12/18/08 with diagnoses that included status post hip fracture and osteoporosis. Review of the quarterly MDS (Minimum Data Set) dated 9/20/09 revealed that Resident #30 exhibited modified independent cognitive skills for daily decision-making. The same MDS also revealed that Resident #30 was independent for bed mobility, transfer, ambulation in her room and ambulation off and on the unit but required supervision for ambulation on the unit corridor. In an interview conducted with Resident #30 on 10/22/09 she responded "no" when asked if any non-pharmacological alternative methods were offered her when having pain. However during an interview on 10/22/09 with E11 (nurse) she cited non-pharmacological interventions provided Resident #30 to address her pain. Review of the clinical record revealed initial development of a	F 280	The MDS Coordinator completed a chart audit on 11/18/09 to ensure care plans reflect non-pharmological interventions on residents that are prescribed psychoactive medications. Attachment #14. The Admission Coordinator reviewed care plans on 11/18/09 to ensure all careplans have measurable goals and interventions to address pain effectiveness. Attachment #15 3. All nursing staff will be in serviced on initiating, revising and updating care plans. Currently, the nursing staff is responsible for monthly summaries and quarterly assessments on assigned residents. Reviewing care plans on their assigned residents will be added to their responsibilities – nursing will be inserviced on the added responsibility of checking care plans. 4. The MDS Coordinator currently reviews 5 charts per month to ensure psychoactive medications are care planned accurately with reason for use, side effects and non-pharmological interventions. The Admission Coordinator will review 5 charts per month to ensure care plans reflect assessed pain, interventions and the effectiveness of the interventions. The	11/18/09 12/11/09 12/11/09

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F 280	Continued From page 10 care plan on 12/30/08 for pain was reviewed on 5/16/09, 6/30/09 and 9/25/09. Further review of the careplan revealed the absence of any documented non-pharmacological interventions or alternative methods of pain relief. 4. Cross refer F309 #3. Review of the clinical record revealed development of Resident #5's care plan for the problem "(Complaint of) pain (secondary to compressed lumbar fracture)" was initially dated 6/19/09 and reviewed 7/27/09 and 9/22/09. Each review of the care plan also included the goal "will have relief from pain til (discharge)" and the intervention "Pain meds prn (as needed)". Further review of the care plan revealed that the medication, Flexeril, prescribed on 10/22/2009 by Resident #5's physician was included among the interventions. Additionally the statement "10/21 & 10/22 neck pain" was added to the right margin of the same care plan. However clinical record review revealed a form "Pain Flow Sheet" with a start date of 10/1/09 dated that indicated headaches sustained by Resident #5 and located at the back of her head and proximal to her neck were present from 10/17/09 through 10/21/09. These headaches were rated moderately severe and ranged between six and eight on a scale from 1 to 10 but failed to be included in the care plan. The facility failed to review and revise a care plan with measurable goals and interventions specific to the headaches experienced by Resident #5 between 10/17/09 and 10/21/09. In an interview with Resident #5 on 10/21/09 at 12:30 PM she stated that she received Tylenol for her headaches but each administration of the prescribed medication was effective for an hour.	F 280	Admission Coordinator will also review the same 5 charts for care plans to reflect all approaches to preventing skin breakdown. Both the MDS Coordinator and the Admission Coordinator will report findings at quarterly QI meetings.	

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F 280	Continued From page 11 The facility failed to develop a care plan with measurable goals and specific interventions that addressed the effectiveness of pain relief for Resident #5.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and policy review, it was determined that the facility failed to provide services that met professional standards of quality. The facility failed to provide a pain management program that met professional standards of quality for one (R85) resident The facility failed to administer eye drops properly for one resident (R4). The facility failed to implement current standards of practice for pressure sore risk reduction for one resident (R27) Findings include: 1. Cross refer F309, example 1. The facility failed to ensure that the pain management protocol for R85 met the professional standards of clinical practice as defined by JCAHO (Joint Commission Accreditation Hospital Organization), the American Geriatrics Society, and their own facility policy. In particular, this facility failed to record a pain assessment in a way that facilitates regular reassessment and follow-up in a timely manner. In addition, as required by the standard of care, the facility failed to continue to use the same quantitative pain assessment tool used for the initial assessment of R85's pain on 10/13/09.	F 281	1. R85 has been discharged from the facility. We are unable to go back to make any changes to her chart. R4 did receive her ordered eye drops. We cannot change the procedure that was done during observation. R27 was active and mobile. She was able to move independently in bed and relieve pressure by herself. Heels were elevated. R27 has been discharged from the unit free of any skin breakdown. We are unable to go back to update care plan. 2. Residents that have pain are at risk of not having pain reassessed using a quantitative pain assessment and followed up in a timely manner. Residents receiving eye drops are at risk of not having eye drops instilled using facility policy and procedure. Residents who need to have pressure relieved while in bed are at risk to not having care plan reflect all approaches used to relieve pressure. Nursing will be in serviced on policy and procedure of instilling eye drops. Nursing will be inserviced on using the same quantative pain assessment tool used for initial assessment.	12/11//09

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F 281	Continued From page 12 2. Med pass observation was conducted on 10/20/09 at 11:50 AM when E4 administered Systane eye drops to R4. The nurse instilled two drops in the inner most corner of both eyes. Minimal run off from the eye was noted and the resident stated she felt the drops in her eye. The acceptable practice and current facility procedure for the administration of eyes drops stated to use forefinger and thumb to pull down lower eyelid. Instruct the patient to look upward. Instill the drop inside the pouch made by pulling down the lower eye lid. 3. Cross refer F314 example #1. R27 was admitted 5/22/09 post surgery for a fractured right hip. The facility's care plan failed to include approaches to include pressure relief to the resident's heels. The resident developed a red, boggy right heel that possibly could have been indicator of deep tissue damage from pressure. The Wound, Ostomy and Continence Nurses Guidelines include "Relieve pressure to heels by using pillows or other devices. Pillows under calves decrease heel interface pressures (Tymec, Pieper, & Bollman, 1997)". The facility's pressure sore risk assessment completed on 5/22 and 5/31/09 for R27 indicated the need to "protect heels" however no approaches were added to the plan of care. The facility did not initiate off loading of the heels until after a problem with the heel was identified on 6/7/09.	F 281	The ADOHS or designee did a chart audit to review Braden scale. Based on Braden scale score care plans were reviewed to ensure all preventative measures are in place to prevent skin breakdown. Attachment #19. 3. The pain management policy for the facility has been reviewed and revised by the Medical Director and nursing management. Attachment #11A and #11G. All nursing staff will be in serviced on the new policy. New pain assessments will be initiated on all residents once new policy is in serviced and in place. 4. Ongoing monitoring will be done by nsg management to ensure staff are using new pain management policy correctly. The Admission Coordinator will review records of 5 residents monthly to ensure new pain program is being followed and resident's pain is controlled at their acceptable level. Results will be reported at quarterly QI. Staff Educators will include the policy and procedure for instilling eye drops in new hire orientation for nurses. Attachment #20 The Admission Coordinator will review 5 random charts per month to ensure approaches are in place on care plans for residents at risk for pressure ulcers. Results will be reported at quarterly QI.	12/11/09 12/18/09
F 309	483.25 QUALITY OF CARE	F 309		

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F 309 SS=G	Continued From page 13 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and observation three (R85, R57, and R5) of 23 residents failed to receive the care and services necessary to ensure adequate pain relief. It was determined that the facility failed to reassess and failed to monitor the effectiveness of R85's pain management interventions related to the pelvic fracture. This failure and a failure in contacting the attending physician resulted in pain level remaining at unacceptable level of "7" to "8". The facility failed implement effective pain management interventions for R57 when he experienced a flare of arthritis pain on the night shift. The facility failed to provide the care and services necessary to ensure Resident #5 received adequate pain relief. Findings include: 1. R85 was originally admitted to the facility on 10/12/09 with right sided anterior hemipelvis involving the ischial and pubic ramus, anemia, chronic renal insufficiency, coronary artery disease, history of hypothyroidism, sinuitis, hypertension, osteoporosis, and history of mild dementia. An interdisciplinary care plan implemented 10/20/09 for potential for pain secondary to ischial	F 309	On 9/25/09 R85 was admitted to the Reguard Rehabilitation Center in Maryland secondary to right ischial fracture. She was discharged from the facility to home on 10/07/09. Her limitations were mild but present. Attachment #21. R85 was admitted to this facility on 10/12/09 for short term rehab and placement while caregiver was on vacation. She arrived by car from Maryland with daughter and care giver in attendance. Her initial comprehensive assessment reflected no pain by resident. Attachment #22. Family presented list of medications resident received initially at home. Attachment #23. A medication list R85 was discharged with from previous hospital stay was also presented. Attachment #24 Routine meds given at home had no pain medication listed. Admission medications were ordered using the discharge list from previous hospital stay. Attachment#25. Tylenol 650mg was ordered as a routine medication to be given three times a day. Vicoden 5mg/500 mg 1-2 tabs was ordered every 6 hours as needed for pain. R85's last dose was 10/7/09. Attachment #24 Nurses notes reflect no complaints of pain during the night and resident ambulating with assist of one. Attachment #26. On 10/13/09 R85 had a pain assessment completed by a PRN staff nurse. Attachment #27A	

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F 309	Continued From page 14 fracture noted interventions to include pain medication three times per day (TID), comfort measure, and physical therapy treatment. The goal for R85 on this care plan was to have relief from pain and pain would be controlled till discharged. The pain management standards were approved by JCAHO in July 1999 and the same guidelines were approved by the American Geriatrics Society in April 2002 which included: - appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Review of facility's policy titled "Pain Management" noted that a collaborative and interdisciplinary team approach would be emphasized to control pain through appropriate pain assessment and pain management at a level acceptable to the resident. Further, the policy documented the following procedures: #2. On each shift, the resident must be asked if he/she is experiencing pain or observe resident for behaviors indicating pain (while awake). If pain is indicated, refer to the Pain Flow Sheet. #4. Resident will be asked about pain within two hours of implementation of an intervention to determine effectiveness of treatment. Effectiveness of interventions will be documented on the Pain Flow Sheet. Review of nurse's note dated 10/13/09 timed 12	F 309	and #27B. Her pain level was an 8 at the time of assessment. Assessment reflects a 1-5 level is acceptable to resident. R85 had been given 650 mg Tylenol at 9:30 a.m. that morning prior to assessment. Attachment #28. When assessment was completed, R85 was then medicated with prn Vicoden as ordered at 10:45 a.m. Attachment #29. At 12:00 noon on 10/13/09, ADOHS spoke to physician about R85's statement "I don't know why they give me Tylenol, it doesn't do anything for me". New orders were received to discontinue routine Tylenol order and to order Vicoden routinely to be given TID. Physician ordered Tylenol 650 mg to be used for break through pain. Attachment #26, #30 & #31. R85 was to be given Vicoden at 9:00 a.m. prior to therapy, again at 3:00 p.m. for after the day's activities and again at 9:00 p.m. to help with sleep. This time frame also reflected the same every 6 hours that was originally ordered when Vicoden was a prn medication. Giving Vicoden on a routine basis and Tylenol for break through pain would be better controlled. Having routine Vicoden would allow the Tylenol to be a better adjunct for pain control. The October MAR does reflect asking R85 whether she had pain every shift. This is asked of all residents as a standing order on the MARs. The pain flow sheet is to be completed with the	

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F 309	Continued From page 15 noon by ADON (E3) documented R85 asking "I don't know why they give me Tylenol, it doesn't do anything for me." During an interview with the ADON (E3) at approximately 9 AM, E3 related that R85 agreed to use of the Tylenol for breakthrough pain and that the resident agreed to this plan of care. Review of R85's admission "Pain Assessment" dated 10/13/09 indicated R85 was experiencing pain related to pelvic fracture sustained on 9/25/09. R85 reported that the pain level was "7" or severe at the time of the assessment and the acceptable pain level for R85 was between "1-5" or mild to moderate. The current physician's order included Vicodin 5/500 one tablet routinely TID given with Tylenol 650 mg. for breakthrough pain as needed. The assessment noted that the effectiveness of these medications would need to be determined since this was a new intervention and was initiated on 10/13/09. Review of R85's October 2009 MAR (medication administration record) revealed that the resident was prescribed Vicodin 5/500 one by mouth TID and was administered at 9 AM, (approximately six hours span in between) 3 PM (approximately six hours in between), and 9 PM (approximately 12 hours span in between). In addition, Tylenol 650 mg. by mouth every 4 hours as needed (PRN) for breakthrough pain. Additionally, the October 2009 MAR documented that R85 was asked whether she had pain every shift, per facility policy, as noted above. Review of the "Pain Flow Sheet" noted the following directions to complete this form if resident: - requests pain medication	F 309	acceptable level of pain for each resident listed. The pain flow sheet would only be used for prn medication and not routine pain medication per the current policy. You would expect to have the question of pain be documented as yes because the resident is receiving routine pain medication. The pain flow sheets reflect the extra Tylenol R85 asked for in between getting the Vicoden. Attachment #28. Nurses notes 10/13 to 10/22 reflect that R85's pain was being addressed but did not use numerical scale. Attachments #26, #30, #32, #33 and #34. R85 had access to call bell at all times when in room and did bring to staff's attention when pain was past her acceptable level as reflected on pain flow sheet for Tylenol. Attachment #28. All extra pain medication (Tylenol was effective although numerical scale was not used to reflect so.) The pain flow sheet reflected the assessment of resident's pain. R85 was given routine Vicoden. If resident complained of pain afterwards or gave an indication of pain, the nurse would write assessment on pain flow sheet using numerical scale. Documentation in the nursing notes should reflect that medication other than routine medication was given and the results. On 10/21/09 at 12:15 p.m., resident did receive Tylenol and ice for complaints of pain that she had rung call	

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F 309	Continued From page 16 - complains of pain - has a significant change in pain - has a behavior indicating pain. In addition, R85's acceptable pain level, as noted in the above pain assessment was not documented. Further review of the Pain Flow Sheet (PFS), out of the 20 shifts for period of 10 days (10/13/09 through 10/22/09), R85 reported having pain on eight shifts, however, only two shifts; 7 AM - 3 PM shifts on 10/13/09 and 10/21/09 documented the information on the PFS. The information contained the time of the pain, intensity of the pain utilizing the numerical scale, location of pain, interventions implemented, including medication and or/non-pharmacological. The staff failed to utilize the numerical scale in assessing the effectiveness of the intervention and noted "effective." Review of R85's nurses notes for this ten days period of time lacked evidence of any assessment of the pain voiced for the remaining six times that the resident offered complaints of pain. An interview with the E2 on 10/22/09 at approximately 12:20 PM confirmed that the facility's expectation was when a resident complains of pain, as documented for the remaining six shifts, that the licensed staff nurse would assess the pain utilizing the PFS. In addition, the DON confirmed that the clinical record, specifically, the nurses notes for the same period of time lacked evidence of pain assessment. Multiple observations and interviews with R85 from 10/21/09 through 10/23/09 revealed that the resident continued to experience severe levels of	F 309	bell for. Attachment #28. The nurses' notes do not reflect the result of giving the Tylenol. The subsequent interview with R85 at 4:30 p.m. had the resident report that her pain level had come to a 5 which was an acceptable level. Attachment #27A & #27B. The R85 did receive her 3:00 p.m. Vicoden as reflected on narcotic sheet. Attachment #35. On 10/22/09, R85 did receive her scheduled dose of Vicoden at 9:30 a.m. Attachment #35. On 10/22/09, R85 told the physical therapy assistant her pain level was a 7. resident did not offer the complaint until asked. It would be the expectation that staff in therapy would notify nursing of resident's complaint of pain. There was no notification and resident did not request to come back to her room due to pain. Resident continued with her therapy and nurses' notes reflect no complaints offered the rest of the day. Attachment #34. On 10/23/09, nurses' notes reflect that resident slept well with no discomfort. Attachment #34. Her routine Vicoden was given at 9:30 a.m. Nurses' notes reflect no further complaints. Resident out to therapy. Nurses' notes reflect that resident slept well and had no complaints of discomfort through the night. Attachment #34. The physician was not notified by staff of R85's pain issue as there was no indication that the	

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F 309	Continued From page 17 pain (rated between 7-8) in the right hip area: -On 10/21/09 at approximately 12:05 PM, R85 was sitting in the lounger in her room and reported to the surveyor that she was having pain in right hip area although one tablet of Vicodin 5/500 was administered to R85 at approximately three hours earlier 9 AM . R85 reported that when she is in pain, she needs to ask for the pain medication and proceeded to use the call bell. At approximately 12:15 PM, staff nurse (E4) administered Tylenol 650 mg. Review of the PFS documented that R85 rated the right hip area pain at "7" prior to the administration of Tylenol 650 mg. Re-review of the PFS at 4:15 PM on 10/21/09 with the 3 PM to 7 PM shift nurse (E14) revealed that the effectiveness of the intervention was not documented for the Tylenol administered at 12:15 PM. Review of nurse's note for 10/21/09 7 AM - 3 PM lacked evidence of reassessment of pain after the administration of Tylenol at 12:15 PM. Subsequent interview with R85 on 10/21/09 at approximately 4:30 PM, the resident reported that after receiving the Tylenol earlier at 12:15 PM, the pain level came down to "5" which is not acceptable to the patient, however, the pain level now is at "7" and she had not received her scheduled 3 PM Vicodin at this time.	F 309	routine Vicoden with the use of Tylenol was not holding the resident. R85 used call bell when pain was not being managed and prn Tylenol was given. R85 participated in rehab, ambulated in room, ate well and slept well as reflected in nurses' notes. Attachment #26, #30, #32, #33 & #34. The physician was notified of the surveyors concern by the surveyor. The facility did not receive any new orders from the physician. On 10/26 the nurse practitioner made her weekly visit. R85 had been experiencing some nausea and vomiting small amounts one time on 10/24 and again on 10/25. Attachment #34 & #36 The physician was notified and new orders were received. Attachment #37. The nurse practitioner assessed resident for her complaints of nausea and vomiting and after conversing with surveyor also pain. Nurse practitioner's notes reflect resident stating she has had issue with nausea and vomiting since she has been here. There is no evidence to this statement. Attachment #38.	
	- On 10/22/09 at 9:25 AM, R85 was observed sitting in a lounger and reported right pelvic area pain at a level of "7" and does not recall receiving any pain medication. R85 was asked what helped with relief of pain and she reported pain medication. The surveyor inquired which pain medication and the resident replied, "Vicodin and not Tylenol." Approximately 20 minutes later, staff nurse (E8) was interviewed. E8 reported that R85 did complain of pain and routine Vicodin		R85 states pain has been up and down. Nurses notes 10/20/09 reflect conversation with resident by ADOHS shortly after surveyor where resident states "it's about the same as always – not too bad but you know I don't like to take pills" when asked about pain. Attachment #36. New orders received from nurse practitioner for a duragesic	

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F 309	Continued From page 18 5/500 was administered (9 AM scheduled dose), however, there was no assessment of the pain including the level experienced by the resident. E8 related that it is her understanding the documentation of the pain assessment on the PFS was only for as needed pain medications and not routine, therefore, would not include the Vicodin. - On 10/22/09 at 10:45 AM, R85 was observed in the therapy department and R85 related to the surveyor that the pain is not any better approximately one hour after receiving the routine Vicodin. A physical therapy assistant (PTA), E7 asked R85 what is your pain level now and the resident replied "7." -On 10/23/09 at approximately 8:57 AM, R85 was observed in a lounger moving lower extremities/squirming. R85 reported moving lower extremity somehow helps with pain relief. R85 related since being in the facility, the pain is worst in the morning prior to therapy and rated the pain during the interview at "8." An interview with a staff nurse(E8) on 10/23/09 at 9 AM revealed that she checks whether a resident has pain every shift typically during first medication pass and has not assessed whether R85 is experiencing pain this shift. During this interview, the surveyor informed E8 that the resident reported pelvic area pain at "8". An interview with the ADON (E3) on 10/23/09 at approximately 9:20 AM revealed there has been no change in pain management intervention or contact with the attending physician (E9) since the conversation with surveyor on 10/22/09 as R85 did not offer any complaints per the shift report. During this interview, E3 was advised	F 309	patch for pain. This is the most prudent approach to pain management for someone experiencing nausea and vomiting. R85 has since been discharged from the facility. R57 has been discharged from the facility. We cannot go back to complete any missed documentation. Nurses' notes do not reflect residents request for oxycodone until the morning of 1022/09 at which time the doctor was notified and oxycodone was given. Attachment #7. The pain flow sheet reflects resident was medicated with Tylenol without results documented in a numerical scale. Attachment #6C 1. R5 was medicated for head and neck pain. There is no documentation that R5 only received relief for 1 hour after receiving medication. The shortest amount of time documented between requests for pain medications was 4 hours with most requests having eight or more hours between request. Attachment #9A and #9B. An assessment made by RN on 10/21/09 revealed location of pain being lower cervical area of neck area at shoulders. Attachment #9C. Resident has a diagnosis of status post compression fracture of 4th lumbar vertebra.	

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F 309	Continued From page 19 R85's pain level of "8" at 8:57 AM today. At approximately 3:30 PM on 10/23/09, the surveyor approached E3 and asked if the attending physician (E9) was notified of R85's pain issue and E3 replied that the facility had not contacted E9. On 10/23/09 at approximately 4:15 PM, E9 contacted the surveyor. The surveyor related to E9 that throughout the survey, R85 had been reporting right hip area pain at a level of "7 or 8". Additionally, that R85 had been displaying lower extremities movement which R85 reports is related to the pain. The surveyor verbalized concerns with the ineffectiveness of the current pain management regime for R85 and requested a reassessment by E9. No reassessment of the current pain management for R85 was completed from 10/23/09 through 10/25/09. The facility failed to ensure that R85 was reassessed for pain management by the physician for over a 48 hour period. An interview with the Nurse Practitioner (E10) on 10/26/09 at approximately 9:45 AM revealed that E10 will assess R85 due to nausea and vomiting as well as pain not being well controlled. Subsequent interview with E10 at approximately 12:30 PM revealed that the plan is to change the pain management regime from Vicodin, a short acting analgesia to a longer acting, Duragesic patch. Review of E10's progress note dated 10/26/09 documented that R85 stated that she received the Vicodin this AM then suddenly vomits and this has been an issue since admission. In addition, pain has been an issue. Revised plan for pain included Duragesic (a narcotic pain medication	F 309	Resident was ambulating hall, eating as usual and able to participate in activities. On physicians visit, he was made aware of R5 head and neck pain for which he ordered flexeril 3 times a day. Attachment #10 R5 has had no further complaints of head and neck pain. 2. All residents are at risk for not being assessed for pain, medicated, reassessed for response to medication and have documentation in place per policy reflecting interventions and results for acceptable pain management. A chart audit has been completed by Admission coordinator/designee on all charts to review pain assessments, pain flow sheets and MARS to ensure resident pain is documented at an acceptable level. Attachment #12. Nursing will be inserviced on consulting physicians timely on resident changes. 3. A revised pain management policy has been developed. Attachment #11A thru #11E. A detailed educational class will be held with all nursing staff to learn the revised policy. Once nursing has been Serviced, all residents will have a new pain assessment completed and the new policy will be initiated.	12/11/09 12/11/09 12/15/09

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F 309	Continued From page 20 administered continuously around the clock for treating moderate to severe pain) patch 25 mg every 72 hours for one week and reassess, Vicodin 5/500 one tablet by mouth with food every 6 hours for breakthrough pain, and Zolfran (medication to prevent nausea and vomiting) as needed for nausea. Although the facility initially assessed R85's pelvic fracture pain and implemented new interventions on 10/13/09 for pain management, the facility failed to reassess and monitor the effectiveness of these interventions as it relates to resident's goals and current standards of practice. In addition, the facility failed to modify the approaches as indicated and failed to communicate with the physician when a resident with pain was not adequately managed. Due to these multiple failures, R85 was found to be in severe pain throughout the survey. Findings reviewed with administration on 10/26/09. 2. R57 was admitted to the facility from the hospital on 9/9/09 with diagnoses which included aortic stenosis (causing pain), pulmonary fibrosis, hypertension, rheumatoid arthritis, coronary artery disease, insomnia, gout and hypothyroidism.	F 309	4. Admission Coordinator will review 5 residents' records monthly to ensure compliance with new pain policy. Results will be reported on at quarterly QI by the Admissions Coordinator.	
	Pain assessments done on 9/9/09 and 9/19/09 indicated the resident had pain related to aortic stenosis at a level 4 to 5 respectively. The resident indicated that on a scale of 0 to 10, a pain level of 2 to 3 was acceptable. The initial MDS dated 9/12/09 indicated moderate daily pain with locations of back and stomach. The resident was using a fentanyl patch at 25 mcg / hr since admission. MAR records indicated			

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F 309	Continued From page 21 that the resident also used oxycodone 5 mg q 4 hours prn for moderate pain seven times between 9/9 and 9/13/09. for back or stomach pain levels of 6 to 7 on the 1 to 10 scale. The resident was documented as having pain relief down to 0 on the four doses that were included on the Pain Flow Sheet. One oxycodone dose had no documentation and the other two had incomplete documentation on the back of the MAR. The facility's policy is to document the full assessment on the Pain Flow Record. R57 was admitted to the hospital from 9/13 to 9/18/09. Upon return from the hospital the prn oxycodone was not reordered. The resident's only order for breakthrough pain was Tylenol (APAP). There was no evidence that nursing clarified the omission of this medication upon readmission. On 10/19/09 at 3:45 PM R57 complained of abdominal pain and received two APAP. This was not documented on the Pain Flow Sheet, there was no pain scale used, and effectiveness of the medication was not documented. During surveyor observation of the APAP administration the resident and his son verbalized that R57 could no longer tolerate the abdominal discomfort. The nurse obtained an order to increase the fentanyl patch to 50 mcg / hr and for follow-up with the gastroenterologist. On 10/21/09 at 10:30 PM R57 received two APAP for new onset of left shoulder rheumatoid pain at a pain level of 6 with relief to a 4. An interview with the nurse (E5) and aide (E6) stated they also provided him with heat packs to relieve the pain. An interview with the resident on 10/22/09 around 9 am revealed that he had been up most of the night with severe (8 to 9) pain to his left shoulder.	F 309		

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F 309	Continued From page 22 He stated that he asked for "oxy" (oxycodone) that he used at home for this pain but the nurse did not want to call the doctor at night. An interview with the night nurse E5 revealed that R57 told the nurse that APAP had worked the night before for right shoulder pain so she wanted him to try it again. There was no documentation in the record of right shoulder pain or the administration of APAP for it at any time in the month of October. The nurse [E5] further revealed that she administered APAP and heat packs again at 2 AM for left shoulder pain at a level of 8. There was no documentation of the pain relief but the nurse stated the resident told her he felt better. E5 stated that the resident was observed "sleeping" with eyes closed after the administration of each APAP dose. The nurse, E5 further revealed that she passed on to the dayshift to call the doctor for an oxycodone order. She also confirmed that oxycodone and other pain relievers were available in the emergency box at the facility. Oxycodone was administered at 9:30 AM for left shoulder pain at a level of 8. R57 had new onset of rheumatid pain at a severe level of 6 to 9 without notification of the physician for proper pain management. The resident's pain after two doses of APAP during the night remained at an 8 in the morning. The facility failed to have a comprehensive assessment of R57's pain, response to pain medications and acceptable level of pain. 3. R5 had diagnoses that included atrial fibrillation, congestive heart failure, status post CVA (cerebral vascular incident) hypertension, coronary artery disease, osteoporosis, status post compression fracture of the 4th lumbar vertebra and diabetes mellitus. According to the quarterly	F 309		

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F 309	Continued From page 23 MDS (Minimum Data Set) R5 had a short term memory problem and exhibited modified independent decision-making skills. The above MDS indicated that R5 was independent for bed mobility, transfer and ambulation in her room. The same MDS also revealed that staff supervision was required for dressing, toileting and ambulation on and off the unit and in the corridor. Review of the clinical record revealed the "Physician's Order" form dated October 2009 with an order for "Endocet 5-325 Tablet (Percocet), 1 tablet by mouth every 4 hours" and another order for "Acetaminophen 325mg Tablet (Tylenol), 2 tablets by mouth every 4 hours" each for administration as needed for pain. Further review of the clinical record revealed the facility form "Pain Flow Sheet" dated 10/1/09 indicated Resident #5 was administered Tylenol 650mg for complaints of moderately severe headaches rated between 6 and 8 on eight out of twelve occasions beginning and ending on 10/3/09 then continuing from 10/17/09 through 10/22/09 on the day and evening shifts. The documentation of the effectiveness of pain relief ranged from zeros through 1, 2, and 3. In an interview conducted with the resident and her daughter on 10/21/09 at 12:30 PM it was stated that R5 was experiencing a headache located at the back of her head proximal to the neck for approximately 3 days. During this same interview Resident #5 stated that she had received Tylenol but each administration of the prescribed analgesic was effective only for an hour. Review of the facility "MD book" dated 10/21/09 revealed the entry "(complain) of muscle spasm to back (and) up neck - family request muscle relaxer for a few days...". A message	F 309		

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F 309	Continued From page 24 written within the margin of the above entry stated "Please see patient". Further review of the clinical record revealed a nurse's note dated 10/22/09 and timed 2:30 PM that stated "...MD is to make rounds on skilled unit...to assess/ (evaluate R5)...". Observations conducted on 10/23/09 at 9:00 AM revealed that R5 was in bed but easily arousable. R5 complained of a headache at the back of her head and proximal to the neck. When asked by this surveyor if she had been seen and examined by her physician on 10/22/09 R5 stated "No". The physician came to the facility and a verbal order was given for ordered medication without talking to or examining R5. The facility failed to accurately assess the intensity and severity of headaches sustained by R5 and the effectiveness of pain relief for her headaches. The facility also failed to contact the physician concerning a new onset of headaches from 10/17/09 through 10/22/09 for a resident with a past medical history of a stroke.	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	R27 was admitted on 5/22/09. Her initial Braden scale score was a 13 and would require protection of heels. Attachment #39A & #39B. Nurses' notes reflect heels being elevated as early as 5/23/09. Attachment #40. Care plan and CNA flow sheets reflect barrier cream being applied. Attachment #41A & #41B. Resident was alert and needed minimal assistance early into her admission. A new Braden scale was completed on 5/31/09 due to her	

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F 314	Continued From page 25 Based on record review and interview it was determined that for one (1) (R27) of 23 residents in the sample the facility failed to implement measures to prevent the development of a pressure ulcer for one of three residents with the pressure ulcer care concern. Findings include: 1. R27 was admitted to the facility on 5/22/09 status post right hip fracture with open reduction internal fixation. The initial resident assessment on 5/22/09 indicated no breakdown or redness to the sacral or heel areas and a .5 mm red spot to the right buttocks. The initial care plan for pressure ulcers/skin care included turning q 2 hours, pressure relieving mattress, and calmoseptine to reddened area. There was no approach to offload pressure to the heels of this resident with pain and decreased function to the right hip and leg. The facility's 'preventive measures" based on a Braden Scale pressure sore risk score of 13 did not include off loading heels for pressure relief. It did however indicate to "protect heels" by positioning and/or heel bows and/or skin prep. The was no evidence that these approaches were included on the care plan, treatment record or aide documentation worksheet. There was no evidence that any of these approaches were implemented. On 6/1/09 at 5 am nurses notes documented a stage II wound to the buttocks measuring 1.25 cm by 0.25 cm. Orders for calmoseptine twice a day and as needed were obtained. There was no change from the initial care plan that	F 314	increased activity and mobility. Her score was a 19 which gave indication of being low risk and being able to off set pressure independently. Attachment #39A & #39B. .A weekly skin assessment continued to be done. Attachment #42. Resident was out of bed to wheelchair for long periods of time, leaving the unit at times. Resident was non-compliant with turning. Attachment #43. A stage II is defined as partial thickness of skin loss involving epidermis and/or dermis (i.e. blister or abrasion if caused by pressure). Resident was discharged from the unit on 7/6/09 with no skin breakdown. 2. All residents with decreased mobility are at risk to not having measures implemented to prevent the development of pressure ulcers. A chart audit was completed by ADOHS on all charts to review Braden scale score. Attachment #19. Care plans, treatments and physician orders are all in place to reflect preventative measures being used. Weekly skin assessments are up to date. 3. All residents have a Braden scale done on admission/readmission/and significant change. Based on scores, measures are initiated to try to prevent pressure ulcers. Weekly skin assessments are completed and documented on skin assessment sheet. Attachment #44. Elevating heels will be added to the admission interim care	

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F 314	Continued From page 26 calmoseptine was allegedly being used since admission. On 6/7/09 at 2 pm nurses notes documented that reddened boggyness noted to the right heel. This could be an indication of a deep tissue injury pressure ulcer. Skin prep was applied and the approach to float (off load) heels in bed was added. The above was confirmed with the ADON E3 on 10/22/09. The resident was discharged home on 7/6/09 with no skin breakdown noted.	F 314	plan as an option to use as approach to preventing pressure ulcers. Attachment #44B. All nursing will be in-serviced on the addition of elevating heels to the interim care plans and the use of Braden scale assessments. 4. The Admission coordinator/designee will review 5 random charts per month. A review of the Braden scale and preventative measures in place as a result of the Braden scale score will be done. Skin assessment notes will be reviewed as well to ensure all preventative measures are in place, care planned and ordered. A report will be given at quarterly QI by the Admission coordinator. Attachment #12.	12/11/09
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on temperature readings taken on 10/22/09 in the resident rooms and tub/shower rooms, it was determined that the facility failed to provide water at a temperature to prevent a scalding hazard. Findings include: 1. The bathroom sink hot water temperature in room #217 was 115 degrees Fahrenheit (F) at 2:32PM. 2. The bathroom sink hot water temperature in room #218 was 115 degrees (F) at 2:37PM.	F 323	1. We cannot change the outcome of the water temperatures taken during the survey in rooms 217, 218 and the shower room. The sinks where the water temperatures were taken were located in areas that house residents dependent on staff for care. Only staff used the sinks to obtain bath water and to wash hands after providing care. Adjustments were made to mixing valves and temperatures were recorded by maintenance to reflect appropriate temperatures for room 217 and room 218 and shower room sinks. Attachment #45	11/06/09

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F 323	Continued From page 27 3. The shower room sink hot water temperature in the room adjacent to room #113 was 115 degrees (F) at 2:42PM. Review of the outgoing hot water temperature log for the boiler supplying the health center indicated temperatures of 120 and 115 degrees F on 10/22/09. Maintenance staff (E16) indicated that the temperature typically drops by about 5 degrees F by the time it reaches the health center.	F 323	2. All rooms are at risk for water temperatures to be above or below required 110 degrees. Each room had water temperatures checked and recorded by environmental services. All necessary changes were made to reflect appropriate temperatures. Attachment # 46 3. A log book will be created by the Director of Support Services. Water temperatures in the healthcare area and readings in the boiler room will be logged in. Both areas will be monitored to develop a standard temperature coming from the boiler to deliver the required 110 degrees to the health care rooms. A sample water temperature will be recorded weekly from different healthcare rooms and compared with the boiler temperature by the maintenance department. Adjustments will be made by maintenance if necessary. Attachments #47 4. Weekly recorded water temperatures will be monitored by the Director of Support Services. Results will be summarized into a monthly report. Monthly reports will be reviewed at the monthly safety meetings as well as quarterly QI by the Director of Support Services.	
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			

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F 329	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R75 and R42) of 23 residents in the sample, the facility failed to monitor anxiety medications and failed to state the indication for the medications. Findings include: 1. R75 was admitted 8/5/09. The resident's diagnoses included respiratory failure, hypertension, atherosclerosis, interstitial lung disease with pulmonary fibrosis, osteoporosis, h/o gastrointestinal (GI) bleed, hiatal hernia, fatty liver and anxiety. R75 was hospitalized 8/11 to 8/15/09 for a GI bleed. On 8/15/09 the resident was ordered xanax (anti-anxiety medication) 0.5 mg every six hours as needed for anxiety. An 8/17/09 social service note stated that R75 had increased anxiety after returning from the hospital on 8/15/09 for a GI bleed. The MAR revealed that Xanax was administered twice in August 2009 to R75 (8/16 and 8/23/09). There was no specific behavior beyond "anxiety" documented and there were no results regarding use of the medication included in the record. According to the MAR for September 2009 xanax was administered once daily on; 9/1, 9/7, 9/12, 9/16, 9/17, 9/26, and 9/27/09. The resident was documented as having a positive result on 9/12/09. There was no further documentation concerning the anxiety, behaviors, effectiveness of the medication or use of non pharmological	F 329	1. R75 has been discharged from the facility. We are unable to go back to make changes. R42's care plan was revised to include behaviors and the reason for the use of medication. Attachment # We cannot go back to add documentation to the MAR. The Social Worker's notes reflect behaviors and use of medication. Attachment # 48 2. All residents receiving anxiety medications are at risk for documentation to not reflect reasons for use, adequate monitoring, or non-pharmological interventions. The MDs coordinator maintains a list of residents on psychotropic drugs. Attachment #14A chart audit was completed by MDS Coordinator. Attachment #14. All residents currently on census that receive psychotropic drugs have a diagnosis, non-pharmological interventions listed and are being monitored for side effects and effectiveness. All behaviors to monitor for are listed on behavior monitoring flow sheets and all residents have care plans. The Social Worker will do a chart audit of her notes on the residents listed as receiving psychotropic medications. All notes will reflect use of the medication and any behaviors exhibited by the resident. Attachment #49A & 49B	12/11/09

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F 329	Continued From page 29 interventions. On October 1, 2009 a Behavior/Intervention Monthly Flow Record (BMF) was initiated for depression, agitation and isolating self. On 10/7/09 It was changed to "voicing worry about who is going to help her" and isolating self. No side effect monitoring was initiated. Xanax was administered 10/6, 10/7, 10/10 and 10/14/09. The reason for and responses to the medication were not clearly documented on 10/7 and 10/10. There was no indication for the medication use noted on 10/6 and 10/14/09. R75 had a care plan initiated 8/24/09 for the problem "some anxious health complaints". The approaches included to explain what you are doing, keep informed, give support and prn xanax. Interviews on 10/21/09 with the nurse E11 and aide E12 who care for R75 revealed that the resident becomes anxious about her oxygen tank being full and being left alone in bathroom. Staff indicated multiple approaches they use to calm her. None of this information was reflected on the behavior monitoring sheets or addressed in the care plan. The facility administered xanax to R75 without clearly defining the indication for use in the plan of care, without adequate monitoring and in the absence of personalized non-pharmological interventions. 2. On 9/24/09 R42 Physician's orders added Ativan (anti-anxiety medication) 0.5 mg every 8 hours around the clock (ATC) for restlessness. There was no corresponding care plan for anxiety	F 329	3. Nursing will be inserviced on documenting reasons for use – behaviors exhibited, monitoring of effectiveness of side effect and the non-pharmological interventions used for resident receiving psychotropic medications on behavior flow sheets and care plans. 4. The MDS Coordinator reviews 5 resident records a month on residents using psychotropic medications. She will review for diagnoses, behaviors, monitoring, non-pharmological interventions and MARs to ensure all reflect accurate documentation. Results will be reported on at quarterly QI by MDS Coordinator.	12/11/09

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F 329	Continued From page 30 or restlessness. No behaviors were being monitored. The MAR indicated ativan was held twice on 9/26 and once on 9/29/09 for sedation/lethargy. On 9/29/09 as physician's ordered indicated the ativan was decreased to 0.25 mg twice at day ATC and to hold for lethargy and an order for ativan 0.25 mg every 8 hours as needed for anxiety was also added. On 10/1/09 a BMF (behavior monitoring flowsheet) was initiated for increased agitation and rewritten on 10/2/09 changing the behavior to "yelling at staff and family". According to the MAR on 10/1/09 a prn dose of ativan was administered without a documented behavior, time of use, non pharmological interventions or response to use. Review of social service notes revealed no mention of the behaviors or the use of ativan. R42's use of ativan and the behaviors it was being used to treat were not included on the resident's care plan. An interview with nurse E11 revealed that the resident refuses care, refuses certain caregivers, dismisses staff from room and yells at staff and her family. She further revealed that the behaviors have declined since she was started on the ativan. R42 was receiving ativan without adequate monitoring and without documentation of an appropriate indication.	F 329		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization,	F 334	1. R17, R35, R58, R83 and R85 all had an influenza immunization. R58 and R85 also received a pneumococcal immunization. All residents or legal representatives signed consent to obtain	

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	085053	A. BUILDING _____ B. WING _____	10/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADBURY AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

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F 334	Continued From page 31 each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334	the vaccine. All residents had physician orders to receive the immunizations. All residents received the CDC information on the immunizations they received. Documentation does not reflect that risks and benefits were explained prior to giving the immunizations. We cannot go back to add information to any of the charts after the immunization has been given. 2. All influenza and pneumococcal immunizations have been given to current resident census. Attachment #50 All residents have signed consents and physician orders. We cannot go back and document on the charts after the fact. New admissions are at risk for not having documentation reflecting education being received of the benefits and risks and potential side effects from influenza and pneumococcal immunizations. A new immunization policy for influenza and pneumococcal vaccine as well as a consent form has been created. Attachments 51A-51F. NSG will be in serviced to the new policies and consent forms. Education will include the importance of discussing and then documenting the benefits and risk and side effects of immunizations.	12/11/09

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F 334	Continued From page 32 documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on review of clinical records, facility documentation, and staff interview, it was determined that the facility's influenza and pneumococcal immunization policy failed to have the educational component which ensures that the resident or their legal representative were educated regarding the benefits and potential side effects of the immunizations for five (R17, R35, R58, R83, and R85) out of 23 sampled residents. Findings include: Review of the facility's influenza and pneumococcal immunization policy lacked evidence of the educational component as it related to the risks and benefits of each of the immunization.	F 334	In the interim of educating nsg staff, the ADOHS will be responsible for vaccines – Attachment #52 - and documentations of new admissions. 3. The new immunization policies on influenza and pneumococcal vaccines includes the risk and benefits and side effect information. NSG will be in serviced on new policy and the need to give the information every year prior to getting consent and physician's order. Documentation will be reflected on the charts. 4. The ADOHS will review charts as part of the admission process. Attachment 53. Any resident admitted without influenza or pneumococcal vaccine will be addressed following new policies. The ADOHS will report at quarterly QI of residents admitted without influenza and pneumococcal vaccines to ensure compliance with policy Attachment #54	12/11/09

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F 334	Continued From page 33 1. Review of R17's clinical records revealed that the facility administered influenza immunization in October 2009. Review lacked evidence that the resident or legal representative received education on the benefits and potential side effects at the time the immunizations were offered. 2. Review of R35's clinical records revealed that the facility administered influenza immunization in October 2009. Review lacked evidence that the resident or legal representative received education on the benefits and potential side effects at the time the immunizations were offered. 3. Review of R58's clinical records revealed that the facility administered influenza and pneumococcal immunizations in October 2009. Review lacked evidence that the resident or legal representative received education on the benefits and potential side effects at the time the immunizations were offered. 4. Review of R83's clinical records revealed that the facility administered influenza immunization in October 2009. Review lacked evidence that the resident or legal representative received education on the benefits and potential side effects at the time the immunizations were offered. 5. Review of R85's clinical records revealed that the facility administered influenza and pneumococcal immunizations in October 2009. Review lacked evidence that the resident or legal representative received education on the benefits and potential side effects at the time the	F 334		

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F 334	Continued From page 34 immunizations were offered. An interview with the Assistant Director of Nursing (E3) on 10/26/09 at approximately 1:30 PM confirmed that there was no evidence that the above residents or the responsible party were educated on the benefits and the potential side effects of the immunizations.	F 334		
F 371 SS=D	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations of the kitchen with E15 (Food Service Staff) on 10/19/09, it was determined that the facility failed to protect food during storage. Findings include: Observations at 8:40 AM of the walk-in refrigerator #1 with E15 revealed that two (2) pans containing beef and vegetables were stored on the floor. Interview with E15 revealed that the beef was being thawed for that evening's dinner for those resident's who dine in the Assisted Living Dining Room which included some residents from the long term care section of the continuous community. Findings reviewed with administration on	F 371	1. The pan containing cooked beef and vegetables was immediately placed on a shelf during survey. The product was disposed of and new was made. It was a menu offering for independent living residents and not offered for assisted living or long term care residents. 2. All food has the potential to be improperly protected while being stored. The Dinning Director inspected the walk-in for proper storage of items. Attachment #55. 3. All dining staff will be in serviced on safe storage practices by the Dining Director. 4. The closing manager will monitor the walk-in to insure all items are properly protected while stored. Documentation will reflect findings. Attachment 56. The Dining Director will report findings at quarterly QI. Attachment # 57A & 57B.	11/16/09 12/11/09

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F 371	Continued From page 35 10/26/09.	F 371		
F 501 SS=D	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that the medical director assessed R85's pain and implemented a pain management program that reflected the current standards of practice. In addition, the medical director failed to coordinate medical care in the facility for two (R85 and R5) out of the 23 sampled residents. Findings include: Review of the facility's policy on pain management failed to reflect current standards of practice (pain management standards were approved by JCAHO in July 1999 and the same guidelines were approved by the American Geriatrics Society in April 2002. The facility's policy failed to include: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.	F 501	1. R85 has been discharged from the facility. Cross-reference F309. R5's condition has been a known issue. Since the muscle relaxer, Flexeril had worked for her in the past and based on knowledge of resident by physician, it was tried again and she is now pain free. The resident was put into the physician log book incorrectly. The log book only notes issues and is not used to recommend treatments. Once reviewed by the physician, the physician will question the staff and decide if the resident needs a visit or a change in therapy. R5 is now better and treatment ordered worked well. 2. Residents having pain are at risk to not having documentation in place showing evidence that pain is being managed at residents' acceptable level. A chart audit has been completed by the Admission coordinator to ensure documentation includes pain being managed at an acceptable level to the resident. Attachment #15. All nursing staff will be in-serviced to the proper use of the physician log book.	12/11/09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 501	Continued From page 36 1. Cross-refer F281, example 1 and cross-refer F309, example 1. R85 was originally admitted to the facility on 10/12/09 with diagnoses including fracture of right sided anterior hemipelvis involving the ischial and pubic ramus sustained on 9/25/09. Review of R85's clinical record, staff interview, and observation throughout the survey from 10/19/09 to 10/25/09 lacked evidence that the facility was assessing the effectiveness of the current pain management plan for R85. These findings were communicated to the attending physician (E9) on 10/23/09. Despite notification to the attending physician, no changes were made to R85's pain regime until the reassessment by the Nurse Practitioner (E10) approximately three days after physician notification. 2. Cross-refer F309 example 3. R5 had a past medical history of stroke. Between 10/17 and 10/22/09 the resident complained of headaches at least daily that were rated at a 6 to 8 on a pain scale of 1 to 10 which would be considered moderate to severe in intensity. The resident was administered APAP for these headaches but voiced that the relief only lasted for about an hour. On 10/21/09 a note was left in the physician communication book about the headaches and need to see the resident. On 10/22/09 the physician, who was also the medical director, visited the facility and prescribed medication. Interview with the R5 confirmed that the physician did not talk to or examine the resident before prescribing a muscle relaxer for the headache.	F 501	3. The pain management policies and procedures has been revised and approved by the Medical Director that comply with the American Geriatrics Society Panel on Management of Pain 2009. Attachment 11A-11G. All nursing and physicians will be inserviced on new policy that also reflects how often to notify the attending physician during the treatment of residents' pain. 4. The Admission Coordinator will review 5 resident records monthly to ensure compliance with the new pain policy. Results will be reported on at quarterly QI by the Admission coordinator. Attachment #12.	12/11/09

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadbury at Lewes

DATE SURVEY COMPLETED: October 26, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey/QIS was conducted at this facility from October 19, 2009 through October 26, 2009. The deficiencies contained in this report are based on observations, staff interviews, review of residents' clinical records, and review of other facility documentation as indicated.	Refer to CMS Form 2567-Plan of Correction for F157, F280, F281, F309, F314, F329 and F501.
3201	Nursing Home Regulations for Skilled and Intermediate Care Nursing Facilities	
3201.6.1	General Services	
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 10/26/09, F157, F280, F281, F309, F314, F329 and F501.	

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NAME OF FACILITY: Cadbury at Lewes

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.3.1.3	**Hot Water accessible to residents shall not exceed 110° F.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 10/26/09, F323.	Cross Reference to CMS 2567, F323, Page 27 and 28
3201.7.5 3201.7.5.1	**Kitchen and Food Storage Areas** **Facilities shall comply with the Delaware Food Code.** **This requirement is not met as evidenced by:** **3-305.11** **(A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD:** **(1.) In a clean, dry location;** **(2) Where it is not exposed to splash, dust, or other contamination; and** **(3) At least 15 cm (6 inches above the floor).** Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: **3-305.11** of the State of Delaware Food Code. Findings include:	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross-refer to CMS 2567-L survey date completed 10/26/09, F371.	Cross Reference to CMS 2567, Page 35